State of California—Health and Human Services Agency
Department of Health Care Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

Dear Physician Provider:

Thank you for your participation in the Medi-Cal program. This *Medi-Cal Change of Location Form For Individual Physician Practices Relocating Within the Same County* (DHCS 9096, new 7/08) is **solely** for use by doctors of medicine and osteopathic physicians who are changing business locations within the same county **and** who meet the definition of an "individual physician practice", pursuant to *Welfare and Institutions* (W & I Code), Section 14043.26(b). "Individual physician practice" is defined in W & I Code Section 14043.1(l) as "a physician and surgeon licensed by the Medical Board of California or the Osteopathic Medical Board of California enrolled or enrolling in Medi-Cal as an individual provider who is sole proprietor of his or her practice or is a corporation owned solely by the individual physician and the only physician practitioner is the owner. An individual physician practice may include non-physician medical practitioners employed and supervised by the physician."

Please note that by submitting this form, you attest that you meet the definition of an individual physician practice, that you are changing locations within the same county, and that the most recent application information you submitted to the Department of Health Care Services (DHCS), with the exception of the current change in location being reported, remains true, accurate, and complete to the best of your knowledge and belief. If you do not meet **all** of these criteria, then you must submit a complete application package consisting of a *Medi-Cal Physician Application/Agreement* (DHCS 6210, rev. 2/08) and a *Medi-Cal Disclosure Statement* (DHCS 6207, rev. 2/08).

Once you have completed the enclosed form, please return it to:

Department of Health Care Services
Provider Enrollment Division
MS 4704
P.O. Box 997412
Sacramento, CA 95899-7412

Please carefully read all the instructions included in the *Medi-Cal Change of Location Form for Individual Physician Practices Relocating Within the Same County* (DHCS 9096, new 7/08) and complete each item requested. You will receive notification of receipt of your application package within 15 days of DHCS receiving it. Incomplete forms will be returned.

PLEASE NOTE: Applicants and providers are required to submit their National Provider Identifier (NPI) with each Medi-Cal provider application package and to attach a copy of the CMS/National Plan and Provider Enumeration System (NPPES) confirmation for the NPI listed in the application package.

It is your responsibility to report to DHCS any changes in information previously submitted, within 35 days from the date of the change. Most changes may be reported on a *Medi-Cal Supplemental Changes* (DHCS 6209, rev. 2/08) form. However, you must complete a new, full application package when reporting a change of ownership of 50 percent or more or one of the other changes identified in Title 22, CCR Section 51000.30, subsections (a) through (b).

If you are planning to sell your business or buy an existing business, you may find it helpful to refer to the Provider Enrollment Division (PED) page at **www.medi-cal.ca.gov**. The PED page contains information about enrollment options available to you whenever there is a sale or purchase of a Medi-Cal enrolled provider or business, including the option to submit a *Successor Liability with Joint and Several Liability Agreement*.

If you have any additional enrollment questions, please contact the Provider Enrollment Message Center at (916) 323-1945, or submit your question(s) to the address above or via email at **PEDCorr@dhcs.ca.gov**. In order to submit claims electronically, providers must request a submitter number by completing a *Medi-Cal Telecommunications Provider and Biller Application/Agreement* (DHCS 6153, rev. 12/07), available on the Medi-Cal Web site at **www.medi-cal.ca.gov** by clicking “Forms”, then “Billing”. If you have any questions about obtaining an electronic billing submitter number, call the Telephone Service Center (TSC) at 1-800-541-5555 and select the option for Computer Media Claims.

Provider Enrollment Division

Enclosures (New 7/08)

INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL CHANGE OF LOCATION FORM FOR INDIVIDUAL PHYSICIAN PRACTICES RELOCATING WITHIN THE SAME COUNTY

DO NOT USE staples on this form or on any attachments.
DO NOT USE correction tape, white out, or highlighter pen or ink of a similar type on this form. If you must make corrections, please line through, date and initial in ink.
DO NOT LEAVE any question, boxes, lines, etc. blank. Enter N/A if not applicable to you.

This "Medi-Cal Change of Location Form For Individual Physician Practices Relocating Within the Same County" (Change of Location Form) is solely for use by physicians who are changing business locations within the same county and meet the definition of an "individual physician practice" as defined by Welfare and Institutions (W&I) Code Section 14043.1(l).
This Change of Location Form may be submitted in lieu of a complete application package, pursuant to W&I Code Section 14043.26(b).

W&I Code Section 14043.1(l) ""Individual physician practice" means a physician and surgeon licensed by the Medical Board of California or the Osteopathic Medical Board of California enrolled or enrolling in Medi-Cal as an individual provider who is sole proprietor of his or her practice or is a corporation owned solely by the individual physician and the only physician practitioner is the owner. An individual physician practice may include nonphysician medical practitioners employed and supervised by the physician."

By submitting this form, you, the applicant are attesting that you meet the definition of an individual physician practice, are changing locations within the same county and attesting that your most recent application, including the last Medi-Cal Disclosure Statement, submitted to the Department of Health Care Services, with the exception of the change in location being reported, remains true, accurate, and complete to the best of your knowledge and belief. If you do not meet all of these criteria, you must submit a complete application package consisting of a Medi-Cal Physician Application/Agreement (DHCS 6210) and a Medi-Cal Disclosure Statement (DHCS 6207).

Omission of any information on this form, or the failure to provide required documentation or sign any of these documents may result in denial of this form as provided in California Code of Regulations (CCR), Title 22, Section 51000.50.

You must attach copies of Centers for Medicare and Medicaid Services/National Plan and Provider Enumeration System (CMS/NPPES) confirmation for each National Provider Identifier (NPI) submitted with your application package. You may not submit an NPI for use in Medi-Cal billing unless that NPI is appropriately registered with CMS and is in compliance with all NPI requirements established by CMS at the time of submission.

Instructions

1. "Legal name"—enter the name listed with the Internal Revenue Service (IRS).
2. "Provider number"— enter the National Provider Identifier used at the new business address indicated in item 5.
3. "Business name"— enter the business name if different than the legal name indicated in item 1.
4. "Business telephone number"—enter the primary business telephone number used at the business address. A beeper number, cell phone, answering service, pager, facsimile machine, biller or billing service, or answering machine shall not be used as the primary business telephone.
5. "**New** business address"—enter the **new** business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code. A post office box or commercial box is not acceptable.
6. "Pay-to address"—enter the address at which the provider wishes to receive payment. The pay-to address should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
7. "Mailing address"—enter the location at which the provider wishes to receive general Medi-Cal correspondence. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates. The mailing address should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
8. "Local business license/permit numbers"—enter any local business license or permit numbers for any city and/or county where you conduct your business and attach copies to the application. If this does not apply to you, enter N/A and provide an explanation.
9. Enter the Clinical Laboratory Improvement Amendment (CLIA) certificate number—attach a legible copy of the CLIA certificate. The name and address on the certificate must match the name and address as entered in items 1 and 5.
10. Enter the State Laboratory License/Registration Number—attach a legible copy of the license/registration. The name and address on the certificate must match the name and address as entered in items 1 and 5.

11. "Previous business address"—enter the previous business location.
12. Enter the requested information. Attach to this application a legible copy(ies) of applicant's or provider's current Certificate of Insurance for Liability Insurance that covers premises and operation for this address.
13. Print name of the physician signing the application. An original signature of the individual is required. Include the city, state, and the date where and when the application was signed. See Title 22, California Code of Regulations, Section 51000.30(a)(2)(B) to determine whether you have the authority to sign this form.
14. Enter the medical license number of the provider. Attach a legible copy of the license.
15. Enter the driver's license or state-issued identification number and state of issuance of the individual named in number 1. Attach a legible copy to the application. The driver's license or state-issued identification number shall be issued within the 50 United States or the District of Columbia.

✓ Remember to attach a legible copy of the following, if applicable:

- ☐ National Provider Identifier verification (CMS/NPPES confirmation)
- ☐ Local business license(s) or permit(s)
- ☐ CLIA Certificate
- ☐ State Laboratory License/Registration
- ☐ Driver's license or state-issued identification card
- ☐ Certificate(s) of Insurance for Comprehensive Liability Insurance
- ☐ Medical license

MEDI-CAL CHANGE OF LOCATION FORM FOR INDIVIDUAL PHYSICIAN PRACTICES RELOCATING WITHIN THE SAME COUNTY

Important:

- Read all instructions before completing the form.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- Return completed form to:

Department of Health Care Services
Provider Enrollment Division
MS 4704
P.O. Box 997412
Sacramento, CA 95899-7412
(916) 323-1945

Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

FOR STATE USE ONLY

Check each box below, as applicable. ***Unless both of the statements apply to you, you are not eligible to use this change of location form and must instead submit a complete application package.***

☐ I attest that I am an **individual physician practice** as defined in Welfare and Institutions Code, Section 14043.1(l) and am relocating within the same county.

☐ I attest that, with the exception of the change in location I am reporting with this form, the information in my last Medi-Cal application package, including the last Medi-Cal Disclosure Statement, submitted to and approved by the Department of Health Care Services remains true, accurate, and complete to the best of my knowledge and belief.

Date: / /

1. Legal name of applicant or provider (as listed with the IRS)	2. Provider number (NPI) (attach copy of CMS/NPPES confirmation)
3. Business name, if different	4. Business Telephone Number ( )

5. **New** business address (address number, street, suite number)	City	County	State	Nine-digit ZIP code
6. Pay-to address (post office box number or address number, street and suite number, as applicable)		City	State	Nine-digit ZIP code
7. Mailing address (post office box number or address number, street and suite number, as applicable)		City	State	Nine-digit ZIP code

8. Local business license/permit numbers (attach copy)	9. Clinical Laboratory Improvement Amendment (CLIA) certificate number (attach copy)	10. State Laboratory License/Registration Number (attach copy)

Enter location you are moving from below.

11. **Previous** business address (number, street)	City	County	State	Nine-digit ZIP code

12. Proof of comprehensive liability insurance

Name of insurance company (**attach copy of the certificate of comprehensive liability insurance to this form)**

Insurance policy number	Date policy issued (mm/dd/yyyy) / /	Expiration date of policy (mm/dd/yyyy) / /

Insurance agent's name (first) (middle) (last) (Jr., Sr., etc.)

Telephone number ( )	Fax number ( )	E-mail address

13. Applicant Signature and Identification Information

Printed legal name of applicant (last) (first) (middle)	14. Medical license number (attach copy)
Original signature of applicant	15. Drivers license number (attach copy)

Executed at: _____ (City) _____ (State) on / / (Date)

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on this form is mandatory. This information is required by the Department of Health Care Services, Provider Enrollment Division, by the authority of Welfare and Institutions Code, Section 14043.2(a) and Title 22, California Code of Regulations, Section 51536. The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Provider Enrollment Division at (916) 323-1945.